

MINUTES FOR THE MEETING OF THE BOARD OF THE BOSTON PUBLIC HEALTH COMMISSION Wednesday, April 12, 2017

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Wednesday, April 12, 2017 in the Hayes Conference Room, 2nd floor, 1010 Massachusetts Avenue, Boston, MA 02118.

Board Members Present:

Francis J. Doyle, Esq., Chair Monica Valdes Lupi, JD, MPH, Executive Director Harold Cox Myechia Minter-Jordan, MD, MBA Kate Walsh

Also Present Were:

Stacey Kokaram, Anthony Bianco, Catherine D'Vileskis, Marybeth Bosak, Maia BrodyField, Ana Vivas, Diana Chaves, Heather Gasper, Catherine Cairns, Alex Davidson, Devon McCarley, Mary Bovenzi, PJ McCann, Angelica Recierdo, Fritz Gustave, Osagie Ebekozien, Daphney Jean, Anne McHugh, Margaret Reid, Triniese Polk, Grace Connolly, Oyin Kolawole, Debra Paul, Anjoli Nath, Anna Hertzberg, Marje Nesin, Tim Harrington, Chuck Gagnon, and Kathy Hussey.

Proceedings:

Chairman's Comments

Francis J. Doyle, Esq.

• Mr. Doyle called the meeting to order at approximately 4:06 pm after welcoming and thanking the audience for being there.

Acceptance and Approval of March 7, 2017 Minutes

• Mr. Doyle called for a motion to accept and approve the March board meeting minutes. Dr. Minter-Jordan so moved on the motion which was seconded by Mr. Cox and Mr. Lopes. Mr. Doyle asked if there were any objections, there were none. The Board Members present unanimously approved the minutes from the March 7, 2017 board meetings.

Report from the Executive Office

Monica Valdes Lupi, JD, MPH

Executive Director, Boston Public Health Commission

- Ms. Valdes Lupi noted that last week was National Public Health Week, and we celebrated many accomplishments.
- On the Accreditation front, we "pushed the button" on our document submission for the Public Health Accreditation Board application. This is a big step in the accreditation process, and will be followed by a site visit later this year. A big thank you to Osagie, Ann, Rita, and all the staff who made this happen.

- I'm pleased to announce that we were selected to participate in the Kresge Foundation's Emerging Leaders in Public Health Initiative. The initiative is designed to develop local public health leaders in pairs, and I will participate with Margaret Reid, Director of our Office of Health Equity. We will join 19 other teams from around the country. With the grant (up to \$125,000) and technical assistance, we aim to do transformative work to advance health equity.
- Steve Wright from the AHOPE Needle Exchange received the 2017 Mass. Outstanding Community Health Worker of the Year Award. Congratulations Steve!
- About 30 BPHC staff recently graduated from the "Managing Effectively in Today's Public Health Environment" course. This course was offered by BU and the Local Public Health Institute, and was designed to strengthen the management skills of current or future public health mangers. Thanks to Dean Cox, the Consortium for Professional Development, and BPHC faculty...and congratulations to the graduates!
- BPHC has been in the news. Late breaking news is that we're working with Inspectional Services (ISD) on an E.coli outbreak. You probably heard about the Chicken and Rice Guys which are a combination of a brick and mortar and also a food truck that goes throughout the City. Dr. Barry, who's not here because she's busy working with the public health nurses looking at the samples, and who is intimately involved in the follow-up investigation along with ISD. They are working very closely with the State because there were individuals who got sick and actually live outside the City. I think they've narrowed it down, according to Dr. Barry. She's looking at another E.coli outbreak related to an investigation going on about a company in Kentucky that was involved in a multi-state outbreak with soy butter that was produced there.
- You also probably heard that last week Mayor Walsh rolled out our budget for the city which is \$3.14 billion. Lots of investments in schools, public safety, and our work across the neighborhoods here in the City. Grace Connolly, our Director of Administration and Finance will walk us through what our budget looks like. Our hearing has been scheduled for May 23rd and will be a panel format like last year. It will be the Public Health Commission, myself, Jen Tracey from the Office of Recovery Services, and Chief Hooley from EMS and we'll be co-presenting our budget at the hearing.
- Since our last meeting, I've had the pleasure of speaking a symposia convened by Harvard and BU and GE. Both events really challenged us to think differently about healthy cities, and the role of public health in driving cross-sectoral work to address social determinants of health. The university papers covered the events. Harvard: "Living in the shadows: Health of poor urban women often overlooked." Boston University: "New Approaches for Building Healthier Cities."
- The State House Ways and Means budget was released earlier this week. IGR is working on an analysis of the budget, with specific detail on how it differs from the Governor's budget.
- In terms of Intergovernmental Relations, I've asked Heather Gasper, our Director of IGR, to give some quick updates on the House budget that was released just yesterday.
- Chairman Dempsey noted health care as a focus, so you'll notice in the headlines that Mass Health has been given a lot of attention. There was also a little uncertainty about tax collections and something we'll keep in mind as the budget process continues.
- 900 amendments are due by tomorrow, that's what they're anticipating by the deadline of close of business. Then they'll go over those next week and the debate on the House budget will begin on the 24th. It's a pretty quick process.
- The funding proposals in the House Ways and Means (HWM) Committee budget would generally maintain existing service levels while making small targeted new investments in several areas including housing, education, and substance abuse prevention and treatment.
- In most instances, HWM followed the Governor's budget proposal. This budget counts on only \$180 million in related revenue rather than the \$300 million in the Governor's budget.

- Includes a total of \$616.4 million for the state's public health infrastructure. The HWM proposal is \$4.4 million more than proposed by the Governor, and \$12.0 million more than current FY 2017 budgeted totals.
- This budget proposal reflects the continued commitment to preventing and treating substance use disorder and initiatives. Combined, the funding for services in the HWM budget is \$144.2 million, \$4.0 million more than in the Governor's proposal, and \$2.4 million more than current FY 2017 budget totals. One of the notable pieces is Recovery Services. There was language to change name of BSAS to Bureau of Substance *Addiction* Services Programs and Operations.
- There is a pretty good laundry list of things they're paying attention to. New investments for: New substance abuse beds; Expand the Ma-Access to Recovery (ATR) assistance program; Two new recovery centers for family supports; Extended release naltrexone; Expand and support municipalities utilizing grant funds from Mass. Opioid Abuse Prevention Collaboration; \$500,000 for 15,000 additional doses of Narcan; Advocate community is happy with HWM version.
- HWM recommends spending \$449.0 million on affordable housing and homelessness assistance programs. This recommendation is \$5.7 million less than the \$454.7 million the state expects to spend in FY 2017.
- A little disappointing is Safe & Successful Youth has been decreased along with Youth Violence Prevention from both the Governor's budget and last year's funding. WIC was another noticeable decrease as well as Family Planning from FY17. Family Planning decreased from last year, but did get an increase from the Governor's budget. Community Initiatives: Smoking Prevention decreased from last year's spending, but level to what the Governor proposed. \$3.5 million in Health Promotion and Disease Prevention. It was an increase from last year, but level to the Governor's budget.
- On the Prevention and Wellness Trust Fund, they are anticipating language to be **included** ????to **pick up** fund set, but that language was not included.
- Infectious Disease decreased \$2.5 from FY17, but \$1 million increase from the Governor's budget.
- There's been a little increase in State labs, the CDC and a little bit of an increase for Mental Health services. Those are just some of the things we wanted to highlight and will be following. IGR will continue to review the proposal and amendments as they come become available. We can talk in more detail in the next month or so and will have more on the Senate budget as well. We will closely align with City Hall and advocates to advance priorities. If you hear about impact from colleagues and partners, please contact IGR. Direct any questions to IRG.
- Mr. Cox had a comment/question. Given that the Prevention and Wellness Trust Fund was not in this budget submission, what advocacy is needed now? I know that it needs to be reauthorized. What needs to happen at this point? Ms. Gasper said that was a great question and to clarify, there's a stand alone bill to reauthorize it. The other play was to include language in the budget so that it was done sooner rather than wait for the stand alone bill to pass. Representative ????? is including an amendment with that language to reauthorize and include that in the budget. As many supporters and as many letters we can get in support would be helpful. Talking to colleagues and having them weigh-in with advocacy would be really helpful. Mr. Cox stated we have certainly signed on here as members of this board and have sent letters of support of reauthorization. It's an important program for us not to lose. Ms. Gasper said we could also include a letter of support from the Board that we can include with the budget and could be helpful.
- Mr. Doyle asked if Mr. Cox would like to make a motion to that effect. He said he would and asked for a motion that we include a letter of support for the Prevention and Wellness Trust Fund. Mr. Doyle suggested amending that to notify at least the Boston Public Health Commission about Representative Backes(sp?) specific amendment. Mr. Cox agreed.
- MOTION: Mr. Doyle stated we have a motion on the floor, any seconds. Dr. Minter-Jordan seconded the motion. Mr. Doyle if there were any objections. There were none. Motion was unanimously approve by the Board Members present to include a letter of support for Representative

Backes amendment to reauthorize the Prevention and Wellness Trust Fund be included with the budget.

- Mr. Doyle had a question. The City is, obviously, reviewing all of the major items that are in the House budget. Is there a methodology for amendments? Do you have to go, as you do, with the original bills that are being proposed in any given year? Or is that City Hall? Ms. Gasper responded that it does originate at City Hall. We work very closely with our IGR counterparts there. We'll weigh in with any additions to the budget itself or any exceptions. We have a list that we compile with them. City Hall usually takes the lead on specific amendments, but I can certainly coordinate further and share anything with you.
- Mr. Doyle asked if there was anything that jumped out that requires an amendment or things that we anticipated would be, at least now, in these early stages? Ms. Gasper replied that for BPHC the Prevention and Wellness Trust Fund was the only thing. City Hall has not alerted me to anything else.
- Ms. Valdes Lupi interjected that it's just early, it was only released yesterday. We're working closely with advocates. There is a process where, as Heather pointed out. We bring information from our advocates, analysis that we've done internally with our programs and bureaus and then figure out the appropriate route for the amendments. We can certainly flag some and if you hear of some through your different advocacy groups, we'd be happy to figure out how best to support those with the help of the Board. Mr. Doyle stated that's what he was thinking perhaps if there are specific ones and they're important to flag and City Hall agrees with us proposing and supporting them. And we can do it in our own advocacy areas as well. Thanks.
- Ms. Valdes Lupi commented that in each of her conversations with each of the Board members, you've all been actively engaged from your own respective organizations and associations on advocacy at the Federal front. We continue to monitor the Federal budget. I think we were all happy that the House wasn't able to advance the American Health Care Act. There was an amendment just last week to the bill around invisible risk sharing. It's related to adding \$15 billion in addition to the \$100 billion in the Patient and State Stability Fund, which is in the base language of the house bill, for Federal HHS to subsidize insurers to cover the cost of high-cost patients. This pot of money would go to \$0 after 2026.
- The proposal would also give Secretary Price pretty broad authority in determining reimbursement policies. Many aspects of the program would have to be worked out by HHS, and there's not much detail. We're continuing to monitor it. We are working with our national groups and Virginia Mayer and the mayor in DC in terms of moving things down to the states. The full Congress did not vote on the full bill before recess, which runs now through to April 24th. Heather and Virginia will continue to keep us and the Board up-to-date on this. I've already mentioned that our City Council hearing has been scheduled for May 23rd.
- Mr. Doyle wanted to add on that subject matter that he, Dr. Minter-Jordan and Mr. Lopes were down in Washington a week and a half ago. I think we have a lot of colleagues nationally, certainly with the National Association of Community Health Centers. I also met with the president of America's Central Hospitals(??) because BMC has funded that and I'm a former fellow. Manny and I both spoke with the folks at NAC(sp?) around making sure we're coordinating our efforts particularly during this difficult period for our safety-net providers and safety-net concerns and social justice concerns that we all share. Those avenues are there for you to rely on them to be able to coordinate with you, just let us know.
- Ms. Valdes Lupi noted there was another late-breaker on the Federal front regarding our PHEP funding (Public Health Emergency Preparedness) that we heard late in the day last Friday and are still trying to develop an impact statement internally. We learned that the President is trying to scoop \$49 million from that pot of funding that goes to states. We receive a little over \$1 million to fund our Emergency Preparedness work which is not only Emergency Preparedness, but also in the Infectious Disease Bureau. Heather and I will be working with IGR to not only sign on to the

- NAACHO letter, but also write a letter to the congressional delegation. That might be something that the Board might like to do. I imagine we should probably reach out to Co?? and others. The league, I know, has their own emergency preparedness staff that has been working on this.
- Mr. Cox said he was saddened to hear that. Let's hope that we can turn that around. Can we say we'll follow your lead in that a letter is required? You're saying we would write the letter as a Board, not as individual members? Is that what you're suggesting? Ms. Valdes Lupi said she thought that would be great to include it along with Virginia's and our colleagues in DC. Mr. Cox wasn't sure if that required another motion, but it would certainly be important for us to write on behalf of this important program that serves our community in such an important way. He asked Mr. Doyle if this requires a motion. Mr. Doyle thought it would be great to have it on the record.
- **MOTION:** Mr. Cox made a motion on the floor that a letter will be written in support of continued funding for the PHEP program. Dr. Minter-Jordan seconded the motion. Mr. Doyle asked if there were any objections, there were none. The Board members unanimously approved writing a letter of support for continued PHEP program funding.
- Mr. Lopes asked if there was a national association that has board members, as well as other interested groups, that we could enroll in so we could get regular updates and we could respond as advocates to the letters to our delegation, our personal letters, that is, to let them know we support a particular amendment or continued funding. Ms. Valdes Lupi replied that she didn't know if there was a national correlate for the boards of health, but certainly the National Association for City and County Health Officials (NACCHO) is one that we can share the link with you all afterwards as a next step. They do routine alerts and you can choose which alerts that you want to be part of. We can send that offline as well. Mr. Lopes said that would be great. Ms. Gasper said the American Health Association is another organization that could be helpful. Mr. Doyle asked that when Ms. Valdes Lupi sends out those two (2) links, could she please include our membership link for the Massachusetts Association of Boards of Health. Ms. Valdes Lupi said of course we can do that.
- Mr. Doyle commented that Ms. Valdes Lupi had asked him to represent the Commission a couple of times over the past month. He filled in for Chief Arroyo at the annual fund raising dinner for the Sickle Cell Association. There were many people there from different organizations and a lot of advocates. Two young ladies were being awarded with scholarships. The Association likes to raise money and give out scholarships to high school students who have Sickle Cell. It's so much more difficult for them because of the regimen, the hospitalizations and attendance factors that make it much harder for them to excel in school and these two ladies are doing just that. It was very encouraging to see them get the awards and they're both from Boston Public Schools as well.
- The other event was at the Pieta House, an Irish suicide prevention association founded by Dr. Freeman of Dublin that she started about 10 years ago after losing her sister to suicide. The organization raises money for treatment for suicide prevention and for those that have attempted suicide. She then started an annual fundraising march called "Darkness to Light." Last year about 150,000 people marched in Dublin alone. They now have marches in a number of places. Their office is in New York. Those folks got together at the Irish Consulate to announce they were having a march in Boston this year. The march will begin in Brighton. It's called Darkness to Light, because they literally start in the dark at 4:00am. The march will be on May 6th and they have invited all of you to join them. Monica said she would help get the word out. And perhaps the rest of us could do so as well. About half of those present were young Irish students who are here in Masters or Undergrad programs. They were very energetic and enthusiastic from their own experiences and about making this a success in Boston. They were thrilled to have representatives there from the Commission and the Mayor showing that kind of support.
- Ms. Valdes Lupi thanked Mr. Doyle for representing the Commission at those events. Actually, that "Darkness to Light" is a reminder that we also sent a note to the Board about our interim medical director, Dr. Jen Jaeger. Dr. Jaeger is transitioning and wrapping up some work that she's doing with "State Monica." She's been working with us as a consultant on a suicide surveillance project we're

- doing with Chief Arroyo. She will be stepping in as Interim Medical Director while we work to fill that vacancy. Dr. Jaeger comes to us from the New York City Department of Public Health where she stood out on some work she'd done on Ebola in 2014. In a future Board meeting, you'll meet Dr. Jaeger.
- Mr. Doyle commented that it's interesting that when he asked to represent the Commission at those events, he became more aware of what the Commission is doing in those different areas just by my association with that event. All the work that's being done with the Samaritans and what's being done for suicide and Sickle Cell as well is edifying for me. Congratulations to all of you who work in the trenches every day for doing this and may not get the recognition for doing so.

Presentation: Update on BPHC's Strategic Priorities Monica Valdes Lupi, JD, MPH, Executive Director, BPHC

- Mr. Doyle noted the next agenda item is Monica has updated and homed in on the three (3) strategic priorities for this year. She will present to us tonight where we are at, where we are headed, and how it is prioritized among the Commission staff.
- Ms. Valdes Lupi stated we have questions, so this will be interactive. I'll go through this quickly so we'll have time for a discussion with the Board. When I first met with the Board in December of 2015, I talked with all of you and then presented my vision for three strategic priorities. I came to those three based on work we had been doing as a public health enterprise both when I was here at the City and then worked at the State Department of Public Health, and then my more recent experience of working with our national association. The three were related to health equity, public health and health care partnerships and then opioid abuse.
- I wanted to start with the framework I've been using in implementing and engaging with our staff and others in the community around those three priorities has really been framed our Public Health 3.0 work. So, a year ago, right after I joined the Commission, our colleagues in Atlanta and DC, our federal partners, had published a report in the American Journal of Public Health about modernizing the governmental public health system and creating a new public health infrastructure. They called it Public Health 3.0. Dr. Karen DiSalvo was at the BU convening last week. She was one of the coauthors along with our former Executive Director, John Auerbach, Dr. Judy Monroe who is at the CDC, and Dr. Patrick O'Carroll who's at CMMI.
- In this new framework, there are some key elements and this is really to trust governmental public health, both state and local health departments, in leadership roles where they are now leveraging a lot of the resources and capacities that we've been developing over the years.
- One of the key elements in this Public Health 3.0 framework is the role of the Commissioner of Health or in this case, the Executive Director of Public Health, to serve in the role of a chief health strategist and to able to bring together different partners in discussions. We're doing that here in Boston, not just me, but in the presentations that you've heard from our colleagues at the Commission, trying to be intentional about bringing together schools, public safety, the housing authority, and transportation in much of our work.
- Another element within this Public Health 3.0 framework, beyond the cross-sectoral work, is the leveraging data in very different ways and using technology. We talked about this at the BU convening. I've talked about it in different community forums and presentations that we, as a public health department, are holders of many different surveillance systems, databases. Our role, and we've heard Dr. Shah talk about this, is not to be database historians, but it is to make data available in a timely way so that we can act upon the data that we're seeing about all these health conditions that we're tracking and monitoring. Using data and technology in different ways is another feature of a strong public health infrastructure, Public Health 3.0.
- Being creative about funding, we, especially now given the current federal landscape, need to be much more creative in terms of the funding that we bring into the health department. Both at the

state and local health department here in Massachusetts and in Boston, for quite some time we've been trying to maximize it with third-party billing. We also have been trying to work more closely with our hospitals, who are engaged in different work with the state and the Attorney General's office, on how to leverage the DoN (Determination of Need) and community benefits dollars. We continue to apply for grants because those federal funds are not going to increase in the foreseeable future. So that's kind of the backdrop for Public Health 3.0.

- I'll start with the timeline. December of 2015 is when I first presented those three priorities to the Board. Starting last summer into the fall, we began holding all staff meetings where we talked about each of the priority topics. We began to have conversations with our staff to gage what work had already been underway so that we could leverage activities and then gather some of their ideas about how we might do our work differently. It was important for me coming into the health department was that our staff and programs saw themselves in these three strategic priorities.
- We had goals with the leadership team. While those were good goals to have, and there were actually some measurable progress on outcomes around the work we were doing on Chlamydia, they were really falling into one area of the Commission. It was important for me to engage all of the different parts of the Commission, all our forty (40) programs, all our public service health centers.
- So we did a lot of this info gathering and environmental scanning into the fall. In the winter months, I'd say through November 2016 to the beginning of January 2017, Rita, Huy and I each led a working group which was represented by the staff that is in the room today. Many staff from other parts of the bureaus and public health service centers really represented a nice cross-programmatic, cross-bureau working group. Rita, Huy, and I facilitated a series of working group meetings where we began to build out project charters, create vision statements, and began to think about potential measures for that work.
- We have the draft plans and before Huy left, we agreed that it would make sense for us to have a smaller sub-set of staff be sequestered for a couple day retreat. We just did that last week. There were about 20 of us, team leads and staff from the Executive Office who met for about a day and a half. We went through all of the artifacts and documents from the different working group meetings and looked at different cross-cutting activities that we saw as themes that were emerging. We tried to help connect the dots across the three strategic priority areas. That convening was facilitated by our colleagues at JSI (JSI Research & Training Institute, Inc.). We're in the process now of finalizing those retreat documents, building a consolidated plan and some visuals to help display the work that we've done. You'll get a little preview of one section of that work this evening.
- The first Strategic Priority is around advancing health equity. This chart should look familiar, the Triple Aim of Health Equity pyramid. It's a visual I helped to create with the Minnesota Health Officer while I was still at ASTHO. The yellow part is around implementing health in all policies. The red part is around expanding our understanding of health. We're looking at cross-sectoral work and social determinants of health and how that impacts community health. The third part, the blue section is related to community capacity. We're doing a lot in our Office of Health Equity around community engagement and how do we begin to give our residents, our community members the tools that they need to become more engaged in the development of programmatic policies and designing those programmatic activities for us.
- The second Strategic Priority is around treating and preventing opioid abuse and looking at a continuum of care. I think this Board is very savvy so I don't need to go into the data justification for this. This is obviously something that all of you as Board members. I know Myechia is leading many local and statewide convenings and advisory groups on the topic. Kate herself is also launching her new Grayken Center. We're also working closely with the state, federal colleagues, national colleagues, and other cities on this issue, this epidemic that is really taking a toll, not only here in Boston, but throughout the country. This is something that is very important. The Mayor has really taken a leadership role in this area. He's a Chair of a Working Group at the US Conference of

- Mayors and has really been a leader, not just for us in the City and the State, but nationally in working with Mayors across the country.
- The third Strategic Priority is around the work that we do to strengthen our collaborative activities between the local health department and our broader healthcare community. We're really lucky in Boston that we have such a rich network of hospitals and also community health centers. We're the envy of many cities. So we need to be in touch, as the local health department, about how we're bridging the two worlds; how we're really carrying on the mission of the local health department; and also be agile and quickly adapting to this new landscape we see ourselves in, particularly with changes that are going to be coming with the 1115 Waiver and the work we're doing, hopefully, with our ACOs and then also with changes in the State's DoN and changes in the Attorney General's community benefit roles. So this was the third strategic priority. Let's stop there and see if there are any questions. I'm trying get through this quickly so we can move on to the discussion.
- Mr. Lopes had a question. With Priority 2, I assume you had discussions around much broader substance addiction and substance abuse. Any thoughts around that verses **going or trickling** into opioid use particularly when you look into the Latino community, the African American community, alcohol, cocaine, marijuana use?
- Ms. Valdes Lupi replied that we've talked about every substance under the sun. I've actually changed the wording. Initially when I first came in and it was focused about opioids and prescription drug abuse. Knowing about what we know about what we see in terms of overdoses in this City and a direct tie to opioids and heroine, we've narrowed the language in the strategic priority, but certainly within the actual activities, goals, and objectives, it's flexible. We are working on marijuana. We're working on modern prevention issues around alcohol, marijuana and other substances so there is some flexibility. You're right. It does vary by substance abuse, regional populations and ethnic groups.
- Mr. Cox stated it gets a little confusing to him sometimes when we talk about opioid abuse. Is that actually becoming the "buzz" word for talking about all substances, even though there's a real interest in talking about the specific concerns around opioid? It's interesting in how we just begin to use the language and whether our emphasis is really only exclusively around opioids or if that's just language that's now representing substance abuse and because we've gotten stuck with that language. That's the language that everyone's using and it is the language. It seems like it's being used to think about substances at large. I don't know if that's a question.
- Ms. Valdes Lupi said it's more an observation. I've been and Myechia has been in different discussions where it sometimes depends on the audience and the group's focus. I wish Kate were here because I actually think her center is much broader in terms of addictions at large. With the RISE?? Project, Myechia you're on the board, would you like to say a little about that.
- Dr. Minter-Jordan said, yes, specifically for opioid use disorder. I tend to agree and wonder if we can make this a recommendation as a Board. Even though I hear your point about as you get down to the actual efforts that they'll be more diverse, but if you start as a strategic priority, that language does narrow it down. Also, we have prevention but should also require education. I would suggest broadening that language to "substance use disorder" so that it does capture, particularly if you're creating a strategic plan, that it does capture the broader range. Then as one of the more immediate actions, it may focus on opioids, but it leaves you the space to be able to go into those different issues as they arise rather than narrowing it from the top. Ms. Valdes Lupi thought it was a totally reasonable suggestion because we're doing a lot of work outside of opioids. Thank you.
- Mr. Doyle said it really isn't a reverse about what you said about different audiences that you are in, you hear the terms used in different ways. It's almost as if you use the larger term as Myechia and Manny had suggested and then call it opioid in the right forms because so much of the money that is coming in now is coming in from those that see it as an opioid abuse issue rather than the overall as all of us see.

- Mr. Lopes said it's just important that we don't lose sight of the other addictions. Particularly as a minority/majority city that these other addictions are impacting these different groups and in a very significant. I think the turn there is that, although this is a very important issue, we don't want to lose sight or reduce any of the resources, particularly around alcohol and some of those other substances that are being abused in our communities. I agree and I think going broader and then talking maybe tactically in projects as relates to this strategic priority, talk specifically around the opioid issue but also highlight the great work in other areas that are going on. I assume you're going to have projects and initiatives that are linked to this strategic priority.
- Ms. Valdes Lupi thought that was a really good question and was glad that Harold brought it up. It's definitely something that we can adjust so that it's broader and within the actual objectives, activities, and strategies as we cut across multiple substances in terms of our efforts.
- Basically, and I think I already said this. This is an iterative process. I want it to be and I'm continue to be committed to making sure we that have the collaborative process with the Board, internally with our staff, and also with other external partners who have a lot to contribute to this work. It's also really important for me that many staff, they majority of staff, could see how they could tie back to one of these or all three. In our conversations with staff it is resonating that they at least find themselves in ways that they can participate in at least one.
- The other piece of it, in terms of the over-arching principal that we're using, is that we build on the work that we've been doing around health equity so that is really the over-arching framework. We use the tools and expertise that we are beginning to develop internally around QI to help drive the activities we're doing in terms of selecting measures, how are we defining success, to the way we are laying out a project charter consistently across the three priority areas and using QI and coming up with prioritizing specific activities. So those are really important in terms of health equity framework and QI projection.
- As for the structure for the internal working groups, the team leads have been great. For my work on health equity, Margaret Reid and the health equity office staff has been involved. Rita has been supported by the Bureau of Recovery Services. The Community Initiatives Bureau played a big role in helping Huy bring us up to this point and time. We put the internal working groups on a pause while we had the staff retreat and will be reconvening them after this Board meeting and will report to you after.
- Our project charters are limited to two (2) years to allow us to look at some short-term goals and quick wins, then some more stretch activities for the organization. We'll get into the specifics with some of the examples I'll show you.
- Strategic Map. This isn't really a strategic map. We're in the process of taking everything from the retreat and putting it into a nice visual. This is a busy slide. The top is really related to a vision that we've stated as part of the Health Equity Strategic Priority where our vision with all of these three is to create a thriving Boston where everyone lives healthy, fulfilling lives free of racism, poverty, violence and other systems of oppression. We're really building on the work we've done around structural barriers and anti-racism activities here at the Commission that we're known for nationally. And also looking at ensuring that everyone in the City of Boston has equitable health opportunities and resources that will ultimately help them in terms of achieving optimal health and well-being. So these are the three strategic priority areas and under each are some bullets in terms of goals. I'll quickly go through these and then we'll use the Public Health & Health Care priority for discussion.
- In Health Equity, these are all in draft still, the three goals we've identified include: expanding the understanding and dialogue of what creates health and what creates inequality. The second goal is related to expanding support for and design of place-based strategies that advance what we're describing as "communities of opportunities" across Boston. We're focusing less on the deficits and building on our community assets model. The third is more internally focused to strengthen our workforce development opportunities for staff to integrate equity into program and policy design. We're really institutionalizing the work that we're doing on health equity so that if the board

- member composition changes or if I leave, we've institutionalized the work and it becomes a part of everyone's job here at the health department and help the health equity office with their activities.
- In Opioid Abuse, the first goal is to increase awareness about opioid use disorders among residents. The second is to build on the work that we've been doing to provide harm reduction services. The third goal is, to Manny's point actually, to expand BPHC's role to address disparities you're seeing across access to recovery services. The fourth goal is to engage and strengthen our prevention activities. You see it's in flux and description in terms of substance abuse prevention. The fourth is around our surveillance efforts. We've done a lot to tighten up and to be able to access more real-time data from our colleagues at EMS, but how do we use this to better understand the actual community need and figure out if we're actually making a difference with the different interventions.
- The third is the Public Health & Health Care Priority. The first goal is to strategically lead population health improvement efforts. The second goal is to build effective clinical and community linkages. The third goal is around improving healthcare quality to ensure equity. The fourth goal is around developing finance and payment models to sustain individual and community health promotion and disease prevention services.
- At the base of these columns, there might have been 15, cross-cutting activities that we identified at the retreat last week. Then we lumped and prioritized it and limited ourselves to six (6), which is still a lot, but important to note that across all three, Communications, Community Engagement, Measuring Impact, Social Determinants, Surveillance, Workforce Development, are going to be critical for us to address. You'll see them as cross-cutting themes and activities that come across the three.
- The next slide. If we use the public health partnerships priority as examples in these goals, it's just to give you a sense of what we've come up with so far. The first is around the work that we do lead population health improvement and public health surveillance. How do we use or data to actually address and be more responsive to what we're hearing from external stakeholders that we need to provide more timely data on the health of our communities? We do a lot of work and we've heard Dr. Shah talk about the different requests we get from the hospitals as they're developing their community health needs assessments from community health centers that might be working on grants to provide them with that data as they're doing their community health planning. How do we take the work that we're doing in relation to health and do a better job of messaging the value that we bring in those discussions? So, those are the three objectives of the first goal.
- Next slide. The next one is around that bridging work between clinical and community linkages. There are lots of discussions happening in our retreat, with our State colleagues, and at the national level around extended care teams and the use of community health workers. That's something we have done historically here in terms of training community health workers through our CHEC program and looking at how we can build on our health promotion and home-based prevention activities.
- Next slide. On health care quality, we're building on the work that Dr. Betancourt has led with Huy, Myechia and Manny around our health equity measure sets. How do we drill down to that patient encounter data to paint a more accurate picture of the disparities that we are seeing and continue to see on the health care front and access issues and making sure that, as part of health care quality, that the information we're developing is linguistically accessible.
- Next slide. On the financing and payment levels, we're looking at and being actively involved in discussions with our State colleagues around Determination of Need and community benefits and how that can ultimately shape and improve community health since the hospitals and the health department are on similar tracks in terms of developing community health needs assessments and community health improvement plans. How do we begin to share data in a more seamless way? So, some of us have been involved in that initial kickoff meeting with ?(sounds like knee-hi)? and GE to launch this new Boston health data initiative. So how do we leverage that opportunity?

- The last piece is around alternating payment models and pay for services models and value based reinforcement which is tied to addressing some of the social determinants of health that you're all encountering, for those of you who are involved in the health care delivery side. So whether it's ACO here or an accountable community health, how do you begin to develop those deliberations and discussions?
- Next slide. These are some questions I put together for the Board for us to review and hear your insights. I appreciate that you've already contributed some suggestions about changing language in the way that we describe the priorities, but would really love to hear your guidance and thoughts on these questions. If I may, I'll start with the first question and then we'll open it up for conversation.
- What are external activities that we can leverage to promote our work? I didn't get to highlight a lot of the external work that we're involved in internally. You're all leading similar efforts about integration and transformation space and we'd love to hear your guidance on other external activities that we could be leveraging to promote the work that we're doing on strategic priorities. So that's the first question.
- How will we need to change to meet future changes in the broader healthcare system? The second is related to being agile and adapting to these changing conditions and we'd love to hear your thoughts and recommendations on things that we need to be mindful of and intentional about as we adapt to these future changes that are happening around us and to be part of those discussions.
- The third questions is, from your individual perspectives, we'd love to hear your thoughts about the role of the health department and the role of the Board in helping us figure out opportunities for us to be better engaged with respect to health delivery activities.
- The fourth question, from your respective work and leadership on so many different issues in the City, I know many of you sit on national advisory boards and groups. We would love to hear if there are other stakeholders you think we should approach or engage, both as a health department and as a partnership with the Board, to help move this work forward on our three strategic priorities. We can start in any order.
- Mr. Lopes began saying he could probably answer some of the questions, but instead was going to add another question in a very sophisticated way. How do we not bump into each other? I'm speaking from a health delivery standpoint as we go through this health care transformation, the ACO, the Medicaid ACO in particular. How do we do this work as a Commission and partner, and I think you've done a fabulous job here with some of the partnership opportunities, and not bump into each other? But more importantly, not confuse the citizens of Boston in terms of: where do I go for these types of services, or who's knocking on my door today asking me for information about my child's asthma, to housing issues that I'm faced with. Because as we enter into this new world of Accountable Care Organizations and we're trying to get control over costs and improve quality, a lot of the scope of our work as health care providers is going to expand. We're going to be incentivized or penalized to do this work effectively. Again, how do we make sure that we can leverage the great work the Commission is doing already, so we're not duplicating services? How do make sure that there's some type of reimbursement, if you would, for some of that work? Because frankly, in many of these areas, you do it better than anybody else, so why should we try to replicate that? So, again, more questions than answers. I think that this new world we're entering into very, very quickly, specifically with the ACO and the Medicaid population. It's going to make us try to change and try to do things differently and it's coming up very fast. So again, more questions than answers.
- Ms. Valdes Lupi quipped: I really don't have an answer, I wish I did! There have been so many conversations that we in public health have, we actually know going into the discussion what our ask is and what we want to offer. But with this one, I actually do think the staff and myself are open to figuring out what are we doing in this case already. We've begun to have these conversations as a Board because we don't want to be expanding what we do at the clinical space. In my one-on-ones with all of you, I think that removing/operating the methadone clinic was a smart move on the part of the Board and the Commission because there was another organization that could do that more

efficiently and more effectively. I think the part of getting to the answer of how do we not bump into each other, part of the initial discussion is figuring out what we all are doing first. Then it's a matter of, and because I'm a visual person, it's almost like connecting the dots, mapping it out to see where we are and look for redundancies. Certainly, there are ways we can be more efficient with our partners or with internal expertise and that's a gap you might not be able to fill. I think that's where we begin to see, ok, this is the public health swim lane and this is the health care swim lane. But right now, the water is flowing across the lanes and we're all kind of shifting about. So that's not an answer and part of it is understanding.

Mr. Doyle asked Monica if he could take this to a higher altitude, if you will. I think often we all want to achieve an achievable goal when we see a problem in health. To put it in context around the current substance abuse focus, or substance abuse disorder focus, I've talked to a number of people. We have windows of time in government and in public policy areas. The window is open right now as far as the intention of government, funders, philanthropy, etc. It is unfortunate to some extent, Commissioner Lopes, is somewhat focused on opioid abuse. It's hard to expand that because you lose the attention of funders. But I see, both on the public health commission side, on the policy side, even at City Hall, that our health centers that are a part of Boston HealthNet and our hospitals and others, a lot of activity because everybody wants to do something in this area right now. Quite frankly, I don't think anyone's coordinating it. Maybe it's not even coordinating, maybe it's convening. I think those are great roles for us to take as a public health commission because when we compete, and I think that's what Manny is touching on over particular areas of service delivery activities in response to a public health problem. As a Commission, we don't enjoy the same kind of success that we could in collaborating with many more partners because they see that as competition. A health center might say: look, my board wants to try this idea in our neighborhood and we're going to do that. To be able to take that street input and bring it to a larger system level across Boston when the local citizens or the board may say: I could never talk to Kate Walsh or the head of a major hospital, or even Monic Valdes Lupi, the head of the Commission, but we have some really good ideas in our neighborhood. How do we take that energy both at the intellectual level and the academic level of medical centers that are all addressing this? The bridge, the community health centers have between academic medicine, if you will, and community medicine and community health center involvement. And then local priorities, as Manny said, when he, Myechia and Harold were talking about different neighborhoods, you're talking about different types of populations and different types of problems in these spaces. They also have different ideas about how to address it because of that richness in diversity. I'm thinking that, I would hate to have the window close, have twenty (20) organizations in Boston to try one thing to address this issue or not have tried one of the other 20 things that might have been able to help with these substance abuse disorder issues, because it was responding to the grant or responding to the opportunity, rather than a public policy that had been developed and proposed city-wide, and then help guide people as funding opportunities come up and guide them to one of those 20. There are plenty of people in Boston that are experts in this, I am not one, that have been doing it for many, many years. I know folks at the General and Brigham as well and at the public health school. You get to the point where you say: Gee, let's roll it back five (5) years when there was no money for this. Our people were digging in the trenches doing this every day. Myechia's team over at Dimock, etc. What would we have said back then is: I wish we had money to try this or try that. We were just struggling to keep these programs alive at that point. But right now, we've got a lot of money coming into Boston. It's coming in from the federal government. It's coming in from the state. It's coming in from private philanthropy. All the hospitals are developing their own way of addressing this. All of our health centers, quite frankly, are addressing their own ways of addressing it. I fear that that window is going to close and we'll have lost a wonderful opportunity and have maybe one idea that succeeded. Then provide that program to everyone on a city-wide policy basis. Just a thought, no question. I think there is a roll as the public health policy arm of city government to use bully-pulpit to ease a Mayor who's deeply

- involved in this issue from the bully-pulpit, as well as yourself and the wonderful staff you have here of experts. I don't think we're going to have very much longer on this stuff. We've gotten federal, state, and philanthropic tension that poured money in and GE and like others that BMC received. It's not going to last long. It's going to start shutting down in the next 12 to 24 months. Boy what an opportunity we'd have lost if we were all doing the same thing or trying the same few ideas.
- Dr. Minter-Jordan commented just to build on the parts that both you and Manny raised. In answer to your second and almost your third question. I think the change that needs to happen in the future is to move out of this idea, and I've heard you say this Monica as well, of being a service oriented organization and really being more of the convener, as well as a facilitator, of ongoing efforts that are happening throughout the City. The Commission, I think, has a really unique opportunity, to build on your point, to set the public health agenda for the City and to pull together entities that are working on these things rather than, as I look at the third part of public health objectives, about expanding access and expanding care two miles. It really is facilitating the access rather than expanding because there already are facilities that are already providing the access. And what I hear you say and I agree with, is how do you convene those entities in order to provide access to Boston? Part of what I'd like to see as we continue to do this work, is not just the taking of the data and information, but also the feeding back and helping to develop best practices in order to act on the disparities, in order to enhance access. So the linking together of all the incredible data and expertise that's here with organizations that are doing the work. Part of the change is moving out of this idea of being the expander of access and the service space and moving more so into the facilitator, convener space. That also answers the third point about the role of the department of health delivery transformation efforts is providing the data, forming best practices, and working to enhance the work that's being done by doing those things. I'm trying to pull together some of what I hearing and that was sort of when we met with the Mayor's office and thinking about how does the Commission need to evolve, when the Mayor first became the Mayor, it was around those issues, moving to set the public health agenda, as opposed to trying to deliver it.
- Mr. Lopes thought that was well said. I put down three points here: data, pilot, and testing. I think you said it better in terms of best practices and helping us initiate. I think we've heard a lot of great programs at the Commission, at the Board level, of all the great programs that the Commission is doing, but what we haven't really been able to do is to spread those great programs throughout the City in some cases. It's not necessarily the Commission's role to do that, but the delivery systems role. I think that's where the best practices come in as the Commission tries to pilot or leverage other organizations, or see what other organizations are doing, and bring that back, collect the data associated with it, publish it back to us and say: here you are for this particular issue. Here's what we found works in our particular city and what we'd like to see spread throughout the city. Well said.
- Dr. Jordan wanted to follow-up saying there's no question the Commission's done fantastic work around disparities. Part of what I heard the Mayor say, and that many of us have said, is that we know there are disparities, now what? Our clinical providers say the same thing: I know there are disparities in my patient population. What do I do to address that? And that's the missing piece, getting that information and then working with entities that are providing those services to create access to help address the disparities. We're now at the point where we now need to address the disparities that we know have existed. It really hasn't changed much because we really haven't addressed them. The spirit of all these entities that I've come into contact with is that we want to do that. We need to work together to figure out how best to do that, study that, highlight the best practices, etc.
- Ms. Valdes Lupi had a question for the Board. This is tremendously helpful hearing your impressions, thoughts about public health space and then clinical space activities. Certainly the convener, coordinating role is a natural role. Thank you for just underscoring or punctuating that. The question I had for the Board is in certain instances, we're sort of the organization of last resort, a

- safety net let's say, for the emergency shelter system, emergency medical services. Some on my staff might argue that for home visiting, we play a role in that. That's not what you're talking about in terms of reflecting on public health services because those are key roles for us beyond just the convening and coordinating role. There are certain instances where we do play a more active role in delivering care.
- Dr. Minter-Jordan said the home visiting is an interesting one because what will happen as we transform health care delivery, is that other entities will be doing that as well. They'll do it and will be able to link back into more services. So, I wonder then, how to partner in that regard. There shouldn't be a family that gets a home visit regarding TB from the nurses and then also gets a home visit from staff at one of the community health centers. How do you coordinate those efforts if you already know that the home visiting team is already going out to that home? How do you coordinate those efforts and make them more efficient for families so that you're not having too many people knocking on your door for the same issues. It's around coordinating and being able to understand what is currently happening and being able to plug into that in those instances where the community does side with the Commission. That's where you focus those resources as opposed to having the same effort. I think there's ongoing conversations about how that work is happening, what will be the use of tele-medicine in the future and there may not even be a need for some of the home visiting we're doing. How do you coordinate those efforts in partnership with other entities?
- Mr. Lopes agreed with Dr. Minter-Jordan. He thinks there is a role for the Commission to play in an emergency situation where you could come in and help a situation or address a situation, where the other health care systems would struggle to try to do that. I'm trying to see if we have an example of where we needed you to help us. H1N1 is a good example of where the Commission led the effort and needed to lead it. That's number one. The second would be in the pilot area. There isn't a way to deliver a service currently, and frankly no one stepping forward, and I feel the role of the Commission would be in developing a system or solution for a particular problem, again, testing it, developing the best practice and using that to spread and hopefully get others engaged in the effort. I think, to answer your question, that would be the two areas for delivery.
- Mr. Cox said he was struggling a little bit as he was listening to the conversation and looking at the priorities. Several things stick out for me. On the one hand, when I think about what it means to set a health agenda for our community, when I look at those three things you put up there, especially number one and number two, what would I say we were trying to achieve in five (5) years? It's not clear to me. I don't know what the message is. Are we talking about our role as approving the system? Which I think that's really what one and two really are about. Improving the system so we can address a whole myriad of issues. But it's not clear to me if I try to articulate what are we trying to improve if I look at number one and number two. Do I think those things are important? Yes, I do. Do I know how they will improve our system? No, I don't. That's the first thing. Then as I think about what it means for us to be involved in some of the safety net activities. Yes, there is a place for us and over time, public health has always been involved in those types of things. We moved away from needing to think about our methadone clinic for awhile. We moved away awhile ago about how we deal with sexually transmitted diseases. There have been times that we have moved away. So, it becomes important for us to always evaluate what we're doing and who's doing it right now, do we need to do it. It may make complete sense for us to continue to run our homeless shelters. That may make complete sense. But it also may be a point where we decide that's not really for us any longer and there are other players in the field who can do. That's just one of those things that I think we're continuously need to evaluate. When I come back to the list of the two priorities, I begin to think, so what's going to change in our communities? We do know that we have in our community pockets of great disparity, pockets of activity, and pockets of things you want to change. I'm just not certain where that happens. Does that mean that given what you are articulating here, that we convene others to engage with on diabetes, you name it? And that the role of the health department is to ensure that there are folks who have come together to do those kinds of

- things. That's appropriate. I'm struggling just a little bit and thinking about what's the larger issue? How do we really improve the health? Do I think our role as conveners is important? I do because that's one of the important pieces around the health department. The clarity about what we're doing to improve our health. What's going to be different? What's going to be different in 5, 10, 15 years? It's not clear to me as I look at that list. As I look at number one and number two.
- Or. Minter-Jordan wanted to build on Harold's point. I love the idea of systems and how the Commission can play a role in either creating or facilitating a system. As we look at priority two around substance use disorder. That is a really clear role of creating a system, like with 311 and Jen's work of connecting all the current entities that are providing those services and facilitating access to those services. Rather than creating the priority of treating and preventing substance abuse disorder, create a system of care around substance abuse disorder. Is that the better role of the Commission rather than saying you're going to provide these things? There are entities that are already doing this work. I know the Commission is doing a lot of work in that space as well. It's creating that system and leading the city in the creation and facilitation of that system and bringing stakeholders together to create streamlined, equitable access to Boston in each of those areas.
- Mr. Cox said it might be important for us, as we're thinking about improving our system, to be able to identify which of the myriads of things that we could improve systems on. Which ones do we really want to address. You identified opioid as being one. And I applaud you for that, but there may be others. By identifying those, we know the way you do it is by improving the system. We can address issues about opioids. We can address issues of diabetes. We've got to improve the systems in order to do those types of things. It's a very different way of doing what you've done here. I think the areas about transformation and improving the system are important. You can't do that stuff, you can't address those issues without improving the system. I'm struggling a little bit with how you frame what you consider to be the priorities. I might have thought about going at it from a different perspective. I'm really trying to get inside your head and your team's head in understanding what you've given us to reflect on.
- Dr. Minter-Jordan commented that the goals you have in this third bucket under opioid usage are listed here are all around the system. It's around the surveillance. It's around the awareness. It's around the access. It's about capacity. It's about the development of a system. So, I think if you look at the framework, it could maybe shift a bit to reflect that. All those goals are how you would create a system of care.
- Dr. Betancourt commented that the challenge here is that we're moving into uncharted territory with the push towards pay for value. We don't know how this is all going to come together, but we know certain things. We know, number one, that there is a greater focus on social determinants within health care because we're paying for quality not quantity. So now there's this huge interest in social determinants. We know that the health care system now is pushed to do more in the area of public health which is creating some anxiety and consternation. What I'm seeing is that locally and nationally the pendulum is really swinging towards the important social determinants. I think it's very, very valuable. At the end of the day, I think the pendulum is going to kick back a little bit because ultimately a lot of the social determinants are based on good public policy: living wage, environmental justice. These are things that hospitals and health care systems aren't going to be able to handle on their own, especially with the budgets that are in play. Then the question becomes how do we advocate for better policies that are supporting wellness and keeping heads out of beds and driving health? What's the role for the Commission and us here? That brings me to the conversation of resources. Because at the end of the day, the push is towards value and risk and rewards. We're going to give you some resources here and how can you extend yourself to not do business to prevent illness. Where do we fit in? Part of the discussion should be where do we sit with risk/reward? These contracts come down from, whether it be Medicaid or commercial contracts with health care systems, that are now pushing deeper around social determinants. If we're going to play, I feel like the Commission itself is going to need to think about how to secure resources in a

risk/reward model. So if we're going to become strategic partners with someone, how do we then think about, well we're adding value here, this isn't just about tax payers' dollars. Let's think about risk/reward and how we can fill some of these gaps. I believe there are a lot of economies of scale and there are a lot of incredible things we could do to promote wellness. They have a lot more value now, the health care systems, than they did before. The health care system shouldn't be the only sector that's getting rewarded for the work of the Commission. How do we thread that needle if that makes sense? It's uncharted. I think that we need to think about resources, think about strategic partnerships, think about what we do well, how we can add value, and do it in a way that's synergistic and for the city provides value in general, not just value to hospitals and health centers.

- Mr. Cox said he was thinking about the questions about stakeholders and activities and a couple of things come to mind. One is there is a piece of legislation that you talked about that's looking at how health departments function in Massachusetts. I think there's a way for you to be involved. It will be important for Boston to be seen as a player throughout the state because the Commission is being populated with folks and there's not a seat for Boston. I think we should have conversations with State Monica and think about how to make certain that Boston is engaged.
- Ms. Valdes Lupi replied or not engaged, because I said it depends on what the focus is. It sounds like, in talking with other health officers, it might have a different focus, like rural. Mr. Cox said no, it's really about Massachusetts and there was a reason that Boston was not identified with a seat. I think that there's an opportunity for us.
- The second is there are five (5) schools of public health in Boston, BU, Northeastern, College of Pharmacy, Tufts, and Harvard, that perhaps we should be very engaged with. What does it mean to be a convener? What are the data about people who are thinking about a lot of the kind of things that the Commission is thinking about? On a very parochial basis, we created this new thing called "Life on Albany" which is looking specifically at the individuals who are in the Mass/Cass community area and what's happening at the Boston Medical Center and the Boston University Medical Center and all the schools in that area. It's a much more parochial way of getting engaged. Indeed, the Commission is already engaged, but there are a number of others of those kinds of more local activity that it helps to be involved in in order to take your message further out.
- Mr. Doyle commented in thinking and taking a lot of what was said, we've structured the Commission around, as you identified too Monica, needs that others want filled over the years. Looking at particular populations that perhaps the academic medical system in Boston were not focused on and not causing them to focus on, quite frankly, in filling that hole. Perhaps that's not the future. Perhaps the future is getting to the point where whether it's convening as bully or whatever, if it forces the health systems in Boson to respond to those things that are identified as public health needs that are not being addressed. Perhaps because the pendulum is going to swing. Dr. Betancourt identified exactly where we're going on this. Taking integrated delivery systems, or just pure systems, and marrying them to finance systems is new. That's the newness of accountable care. We've always had HMO's and all the other financing tools before, that tried to do care management and disease prevention and those kinds of things. They weren't the delivery system so there was a dysfunction there already. I think the ACO concept is one that could allow for making the integrated delivery systems or care systems in Boston respond not just because of finances, but if the pendulum swings hard enough in that direction, that's where it will go. We'll be right back to holes in the system and patient populations that are not being addressed by the major ACOs or the major academic medical centers. Then we're trying to fill holes again rather than taking this moment in time in the shift in the payment systems to try and force the agenda, a public health agenda on systems that will largely be, at least early on, the first five years as the funding decreases because it is part of Medicaid ACO that the funding will decrease. Finances are really going to be front and center in those board rooms. Quite frankly, if we don't carve out our territory now, either the systems will carve out what we're to do or what areas they'll allow us to play in because they have the dollars. They're under the risk, so they won't allow a lot of pressure once that is set up as a

public viewpoint, public policy. They're the concentrated entities where the risk and the money lies and the delivery system lies. Therefore, here are the things that the public health commission can be helpful into those things. Or we'll be cut out completely from it. I think there's a short period of time to decide what is our place in that new world that we're going to be in next year, unless everything explodes in Washington. I don't think it will, hopefully. There's a common phrase that people use: if you're not at the table, you're probably on the menu. I want to protect all of the things you mentioned as far as the service delivery systems where we fill the holes right now and have been filling the hole, because no one's readily there to start filling the hole. It would be more in their interest to start. We don't know that yet. We have to protect those populations, those people, those services we currently provide that no one else wants to provide or is ready to pick up and provide. Unless we strategically really think big, we have a window of time on this as well, where we can actually impact our place in that future. We need to do it pretty quickly because it's going to get defined very quickly by the major systems if we don't.

- Dr. Minter-Jordan wanted to make one final point about understanding best practices about the public health commission. We may be the best in the country, which I don't doubt, but I think it would be helpful for the Board to have that context. Ms. Valdes Lupi said she was going to include that in her wrap-up.
- Ms. Valdes Lupi told Frank she hoped we weren't the main course! I think just to close it out what I've heard in terms of themes that have come up from this discussion is that you all, as a Board, support the role of the Commission as continuing to be leaders in the work that we're doing around convening and coordinating. I like the discussion we had in terms of seeing ourselves as building and improving on systems as opposed to being or thinking of ourselves as an expansion of the delivery arm of services. Then we just wrapped up the conversation a bit in terms of, I think, we as an enterprise have been talking about, is how do you then identify what is the value of public health in these discussions and the evolving delivery systems that many health departments in the country are seeing themselves in. Figuring out what we do well, what we could be doing better, and what someone else could more appropriately be doing given the changes in the reimbursement models that we're entering. There are other local health departments and states that we can turn to. suggestion that I wanted to propose, because I knew this would be a really good, engaging conversation, is an idea about whether the Board might want to create a working group to help us at the health department get through some of the questions you posed for us. A working group to help advise us, as we continue to analyze and build out our strategic priorities plans and implementation activities. One part of that might be to invite speakers from other states. The two that come to mind and that I've shared with staff are: Oregon and their Accountable Communities of Care modeled health departments, the devil's in the details. When I've talked with local health departments, they still hadn't seen their part of the reimbursement that had been designed. The other state would be Minnesota. So there is a county example. The population that they were looking at wasn't the population at large, it was more of the high risk, super utilizer group in Hannepin County. Both states and counties have been published. So when we thing about best practice and other places that we could turn to, those two might be a suggestion for the working group if the Board is ok with that. If there are other suggestions on how to continue, to what the Chair has already conceded is a sense of urgency, and not wanting to miss an opportunity to get ourselves organized and to have a more clearly defined understanding and clarity about our role.
- Mr. Lopes and Mr. Doyle thought that was a great idea. Mr. Doyle added that because we're at the front end of this. We're not going to find a lot of examples through states or public health systems that have Medicaid ACOs hoisted on them as the system for all of their Medicaid population. We're at the cutting edge of this. So we'll be edified by those programs that you mentioned, but they won't be directive because we're in a different world than they really are. The one thing I would suggest is that you add to that some of the major commercial groups like Kiser and Geisinger systems. Those commercial systems have been doing this a lot longer is what I'm saying. They may have found in

their own experiences that there was a role for public health if they had only started earlier on. Or that they now would say you guys are starting down this road, particularly with the populations you're starting with, you may want to consider this, that, or the other thing. I think among all of us we've got some connections in those systems.

- Ms. Valdes Lupi said she had just reconnected with **Dr. Shar Shikier(sp?)** who's in Chicago now. Dr. Betancourt said he's on the board with Trinity and in Chicago. He was the former city health officer in Chicago. We spoke just last week because he was here for this convening. He's great because he has that perspective of local health officer, it's a vertical integrated model with Kiser. I think Trinity was also integrated. So, definitely Kiser, Geisinger.
- Mr. Lopes had one last piece on the summary. We didn't talk about data and I think we take it for granted. As these groups are being formed, I think for a lot of the health delivery systems, there going to be looking at what's in front of them, but not looking necessarily at the bigger picture. I think there's a role for the Commission for us to play to make sure we keep everyone honest, if you would, because it is about the finances. For a lot of those delivery systems that we'll be paying close attention to those finances as well as quality. But the greater good of all of the people in this city is where I see one of the key roles. Data helps show whether or not they are truly going to impact the health of the community in a positive way. Let's not miss sight of that in terms of the Commission's role to the monitor, survey, as well as continuing the publishing of where we stand from health equities, etc. that's a key role.
- Mr. Doyle thought that the biggest role from a complete health perspective that most individual systems do not have. Trust me, Monica, every room I've been in we are all talking about this. The one percent that's spending 85% and the 5% that needs the attention of these ACOs in order to drive down the costs of the ACOs. We're talking about 90% plus without having a major focus on these new systems. There's going to be a lot of people out there that aren't going to be the primary focus of any ACO or the business systems around the ACO. However, that prevention and education, along with the many other things mentioned, is just another aspect of this that we have to recognize. Maybe that's a driving force in how we determine what our role is. To recognize systems that are trying to respond to saving money, building quality and value, do so under certain business constructs that we are essentially free of, to some extent in a public policy realm, even if it's only in a bully-pulpit arena.
- Mr. Doyle and Mr. Lopes thanked Ms. Valdes Lupi for opening up like this for everyone. It was great. Ms. Valdes Lupi thanked the Board and said if they'd indulge us, we'll do more of this style of presenting our work and some questions and carve out some time for discussions during the board meeting. I'll regroup with the staff and put together a theme package from some of the closing thoughts and then share it back with the Board. Let's just keep the work moving forward on the working group concept. We look forward to continuing to get your guidance on this. Thank you.
- Mr. Doyle had one last emphasis. It's time to underline and underscore what Mr. Cox said earlier about we do have a lot to nationally prominent public health schools in this city. I don't know if we've ever convened all of them around anything in particular. We might just add that into the thought process.
- Ms. Valdes Lupi replied that we've been having our one-on-ones with the universities and Tufts' Dean of Nutrition has reached out because we've included the Boston schools in our strategic plan.
- Shifting from strategic plan priorities, to some of the more tactical updates and hopefully not challenges. We've got your favorite presenter, Grace Connolly, Director of Administration and Finance to walk us through the FY18 budget and next steps.

Presentation: Update on Fiscal Year 2018 Budget Grace Connolly, Director of Administration and Finance, BPHC

- Due to the lengthy discussion following Monica's presentation, Ms. Connolly gave a condensed update on the FY18 budget. She recapped the background: all-time high revenues from property tax and local receipt categories; AAA credit rating; low state aid; growth in fixed costs, anticipated at 9% for FY17; and the expiration of collective bargaining agreements. Our budget is a two step process: 1) maintenance request and 2) new budget proposals including operational reforms, budget savings, new initiatives and investments, and revenue proposals.
- The Maintenance Request must reflect FY17 operations in terms of FY18 costs. We have to review possible realignments during this period such as: staff transfers and consolidations, streamlining business processes, shared service models, reduce fragmentation and duplication of effort, and enhancing managerial controls.
- A Recommended Budget chart showed the comparisons of FY17 to FY18 budget numbers in the following categories: City of Boston Appropriation (2.34% / \$1,809,972 increase); Federal Grants (-7.82% / \$1,732,875 decrease); State Grants (-25.23% / \$4,864,816 decrease); EMS Billed (7.33% / \$2,512,299 increase); and Non-EMS Billed/Other (17.30% / \$2,622,072 decrease). City of Boston funding increased \$1.8 million or 2.3% over FY17. Non-EMS budget will increase \$1.4 million or 2.67% (Medicaid CPE increase). OT across BPHC decreasing 1.4%. Budget includes vacancy savings of \$700k for FY18 (FY17 was \$447k).
- We have two new budget proposals: EMS Community Assistance Teams and PAATHS expansion to nights and weekends. Also, \$142,974 in non-personnel savings was accepted. The Capital Budget is scheduled for release Thursday, May 13th. We moved facilities critical repairs to the Maintenance budget for FY18. The last items on our timeline are: May final Board approval (5/19) and City Council hearings (5/23) and June City Council vote and all staff meetings to review the FY18 budget.

Adjournment

• After thanking the presenters, Mr. Doyle adjourned this meeting of the Board of Health at approximately 6:05p.m.

Addendum:

This report is a synopsis of the board meeting. Presentations are posted for review the day or two after a meeting to our BOH webpage: http://www.bphc.org/boardofhealth/Pages/board-of-health.aspx. All board meetings are recorded. Requests for a copy of a recorded meeting should be made via: info@bphc.org. Thank you.

RESPECTFULLY SUBMITTED BY:

Kathy Hussey, Board Secretary

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